

1
FOR STATE
HEALTH DEPT.

M
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown Rural Compton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jerrie Miles Brotemarkle		First Jerrie	Middle Miles
4. DATE OF DEATH June 14, 1958		Lost	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marion Everett Brotemarkle		14. MOTHER'S MAIDEN NAME Mable Ann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 478-36-2382 17. INFORMANT Mr Marion E. Brotemarkle Compton, Md.	
18. CAUSE OF DEATH 8/12/57 (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)		Address BROKEN NECK INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident	
20c. TIME OF INJURY Month, Day, Year Hour 2:11 a.m. 6-14 1958		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work Route 275 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown St Mary Md 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED 6/14/58	
ACTUAL SIGNATURE Wm D Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		22b. BURIAL, CREMATION, REMOVAL (S city) Burial 22c. DATE THEREOF 6/17/58 22d. NAME OF CEMETERY OR CREMATORIAL Arlington National 22e. LOCATION (City, town, or county) Arlington, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE JUN 17 '58 24b. REGISTRAR'S SIGNATURE Albert Edward	

B
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
7236

Reg. Dist. No.

07234

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN lb 6hrs.		d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS Patuxent River, Maryland								
3. NAME OF DECEASED (Type or print) Allan Buren Hill		First	Middle	Last	4. DATE OF DEATH June 26, 1958	Month	Doy Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1892	9. AGE (In years (at birthday) 65 yrs.	IF UNDER 14 YRS. Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Naval Air Station		11. BIRTHPLACE (State or foreign country) 		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Evelyn M. Hill 28 Gardner Ave. Middletown		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), <u>stopping the underlying</u> cause lost. DUE TO (c)								
Coronary occlusion								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>William D. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 6/26/58
EXAMINER'S NAME (Type) William D. Boyd M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Andrew's		22d. LOCATION (City, town, or county) Leonardtown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE JUN 30 '58 24b. REGISTRAR'S SIGNATURE <i>Alfred E. Miller</i>						

RECEIVED
STATE ATTORNEY GENERAL OF TEXAS
MAY 10 1962

NAME	ADDRESS	PHONE	POSITION	TERM
John F. Kennedy	White House	WHT 1-2100	President	1961-1963
Vice President	White House	WHT 1-2100	Vice President	1961-1963
Lyndon B. Johnson	White House	WHT 1-2100	President	1963-1969
Barry Goldwater	White House	WHT 1-2100	President	1969-1973
Richard M. Nixon	White House	WHT 1-2100	President	1973-1977
Gerald R. Ford	White House	WHT 1-2100	President	1977-1979
Jimmy Carter	White House	WHT 1-2100	President	1979-1981
Ronald W. Reagan	White House	WHT 1-2100	President	1981-1989
George H. W. Bush	White House	WHT 1-2100	President	1989-1993
Bill Clinton	White House	WHT 1-2100	President	1993-2001
George W. Bush	White House	WHT 1-2100	President	2001-2009
Barack Obama	White House	WHT 1-2100	President	2009-2017
Donald J. Trump	White House	WHT 1-2100	President	2017-Present

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG231 7-3-58 et

07235

7237

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown Kings Highway		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 days Kirk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piney Point				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Nace		First	Middle	Last	4. DATE OF DEATH Jordon	Month June	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1912		9. AGE (In years lost, birthday) 46 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Bud Jordon		14. MOTHER'S MAIDEN NAME Jane Fenwick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Jerry Jordon		Address Piney Point, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33/x		DUE TO Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Arteriosclerosis and hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State)				
21. I certify that I attended the deceased from June 15, 1958 to June 17, 1958 that I last saw the deceased alive on June 18, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Graet Mills, Md.		DATE SIGNED June 1958		
ACTUAL SIGNATURE P.J. Bean M.D.								
PHYSICIAN'S NAME (Type) P.J. Bean M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/58		22c. NAME OF CEMETERY OR CREMATORIUM St. George's		22d. LOCATION (City, town, or county) Valley Lee, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 24 '58		24b. REGISTRAR'S SIGNATURE Debrauch		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a funeral director's permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Charlotte Hall		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS RFD. 1 Box 474	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Lee Mangum		First	Middle	Last	4. DATE OF DEATH May June 1, 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 30, 1938	9. AGE (In years from birthday) 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenters Helper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Walter L. Mangum		14. MOTHER'S MAIDEN NAME Grace Oliver Tubbs		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Walter L. Mangum Clinton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH LIMITED			
929.8		DROWNING			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) DECEASED WAS POOR SWIMMER - GOT ENT IN WATER OVER HIS HEAD			
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p.m. 6/1/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Patuxent River Charlotte Hall St. Mary's	
20f. (City or town) Hanlon Funeral Home				(County) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>W. D. Boyd</i>		DATE SIGNED 6/1/58			
EXAMINER'S NAME (Type) William D. Boyd M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National	
22d. LOCATION (City, town, or county) Arlington, Va.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hanlon Funeral Home 3831 George Ave.				24a. REC'D BY REGISTRAR JUN 3 '58	
				24b. REGISTRAR'S SIGNATURE <i>Asheen</i>	
VS. A15ME 5M 2/57					

REVIEW OF THE LITERATURE ON RECENT - AND FUTURE
TRENDS IN DEMOCRATIC GOVERNANCE

1993-1994

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated office, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					

3. NAME OF DECEASED (Type or print)		First Pauline	Middle Mason	4. DATE OF DEATH June 17, 1958	Year
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1889	9. AGE (In years to nearest day) 69 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James Holly	14. MOTHER'S MAIDEN NAME Apollina Barnes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Wilmer Mason Leonardtown, Maryland	Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. DUE TO (c)		<i>Coronary occlusion</i> immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>William D. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <i>6/17/58</i>
EXAMINER'S NAME (Type) William D. Boyd M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/20/58	22c. NAME OF CEMETERY OR CREMATORIAL Our Lady's	22d. LOCATION (City, town, or county) Medley's Neck, Maryland	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley Leonardtown, Maryland</i>	ADDRESS	24a. REC'D BY REGISTRAR JUN 20 '58	24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>
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RECORDED IN THE OFFICE OF THE CLERK OF THE COURT
AT THE STATION OF THE POLICE DEPARTMENT JACOBSON

ON THE 1ST DAY OF APRIL,

IN THE YEAR OF OUR LORD ONE THOUSAND EIGHT HUNDRED AND EIGHTY EIGHT.

BY THE POLICE DEPARTMENT JACOBSON.

RECORDED IN THE OFFICE OF THE CLERK OF THE COURT

ON THE 1ST DAY OF APRIL,

IN THE YEAR OF OUR LORD ONE THOUSAND EIGHT HUNDRED AND EIGHTY EIGHT.

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ON THE 1ST DAY OF APRIL,

IN THE YEAR OF OUR LORD ONE THOUSAND EIGHT HUNDRED AND EIGHTY EIGHT.

BY THE POLICE DEPARTMENT JACOBSON.

RECORDED IN THE OFFICE OF THE CLERK OF THE COURT

ON THE 1ST DAY OF APRIL,

IN THE YEAR OF OUR LORD ONE THOUSAND EIGHT HUNDRED AND EIGHTY EIGHT.

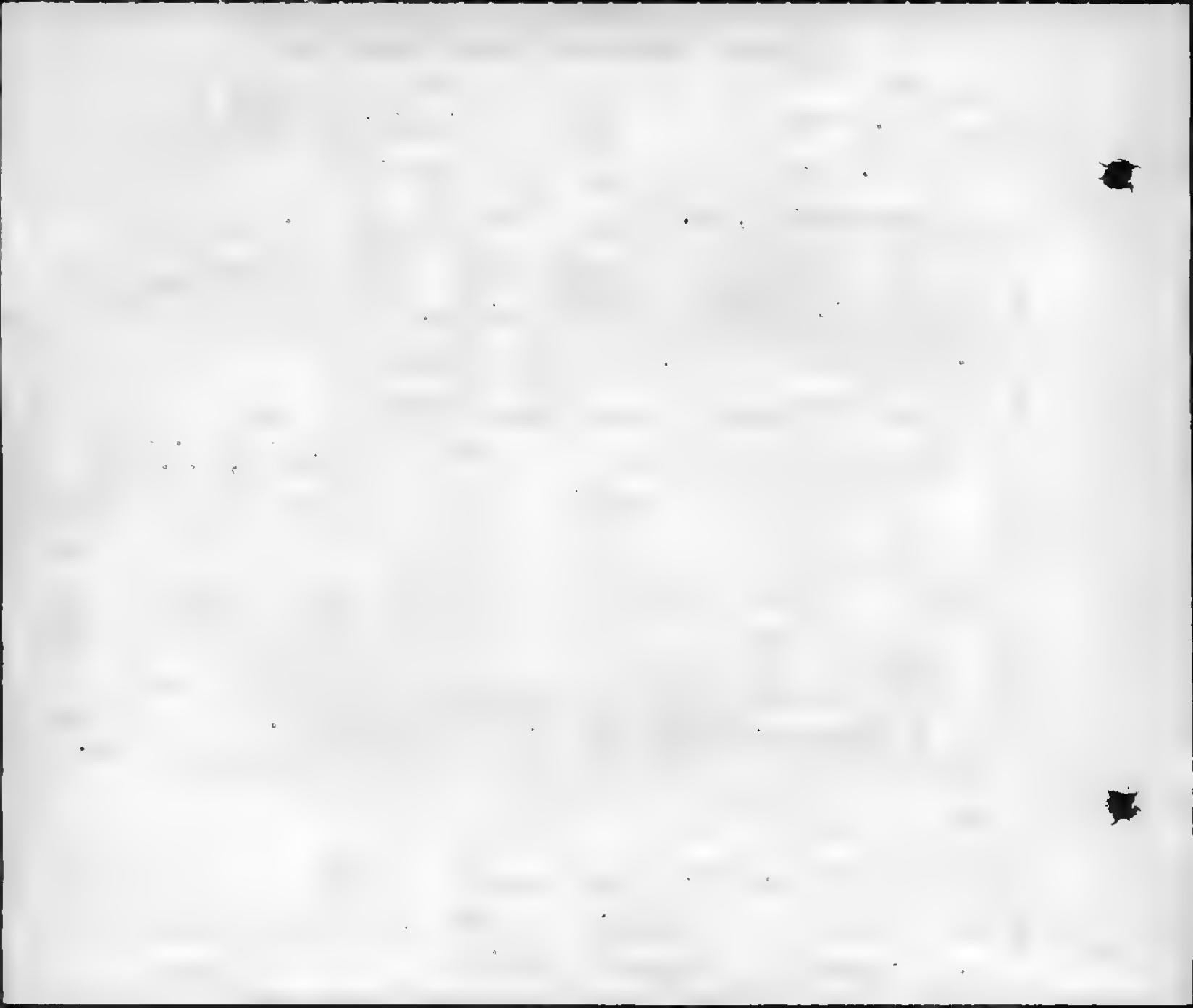
BY THE POLICE DEPARTMENT JACOBSON.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape St. Marys			c. LENGTH OF STAY IN 1b			b. COUNTY District of Columbia			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Mechanicsville, Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
3. NAME OF DECEASED (Type or print) CHARLES			First	Middle	Last	4 DATE DEATH	Month	Day	Year
5. SEX male			6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Gen. Officer			10b. KIND OF BUSINESS OR INDUSTRY US Air Force			11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW 2			17. TERMINAL DISEASE CONDITION Mrs. Maylon - 2917- W . st. S.E.			Address Washington, D.C.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning									INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. X			(b)						
(c)			DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH X			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from small boat- unable to return to boat						
20c. TIME OF INJURY Month, Day, Year Hour 10:05 a.m. X 6/15 1958			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Patuxent River			20f. (City or town) Cape St. Marys, St. Marys (County) Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Wm D Boyd</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 6/15/58
EXAMINER'S NAME (Type) William D. Boyd, MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/19/58			22c. NAME OF CEMETERY OR CREMATORIAL Arlington National			22d. LOCATION (City, town, or county) Arlington, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers			ADDRESS 514- 11 St. S.E. Washington, D.C.			24a. REC'D BY REGISTRAR JUN 18 '58			24b. REGISTRAR'S SIGNATURE Ab. Leach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7241

CERTIFICATE OF DEATH

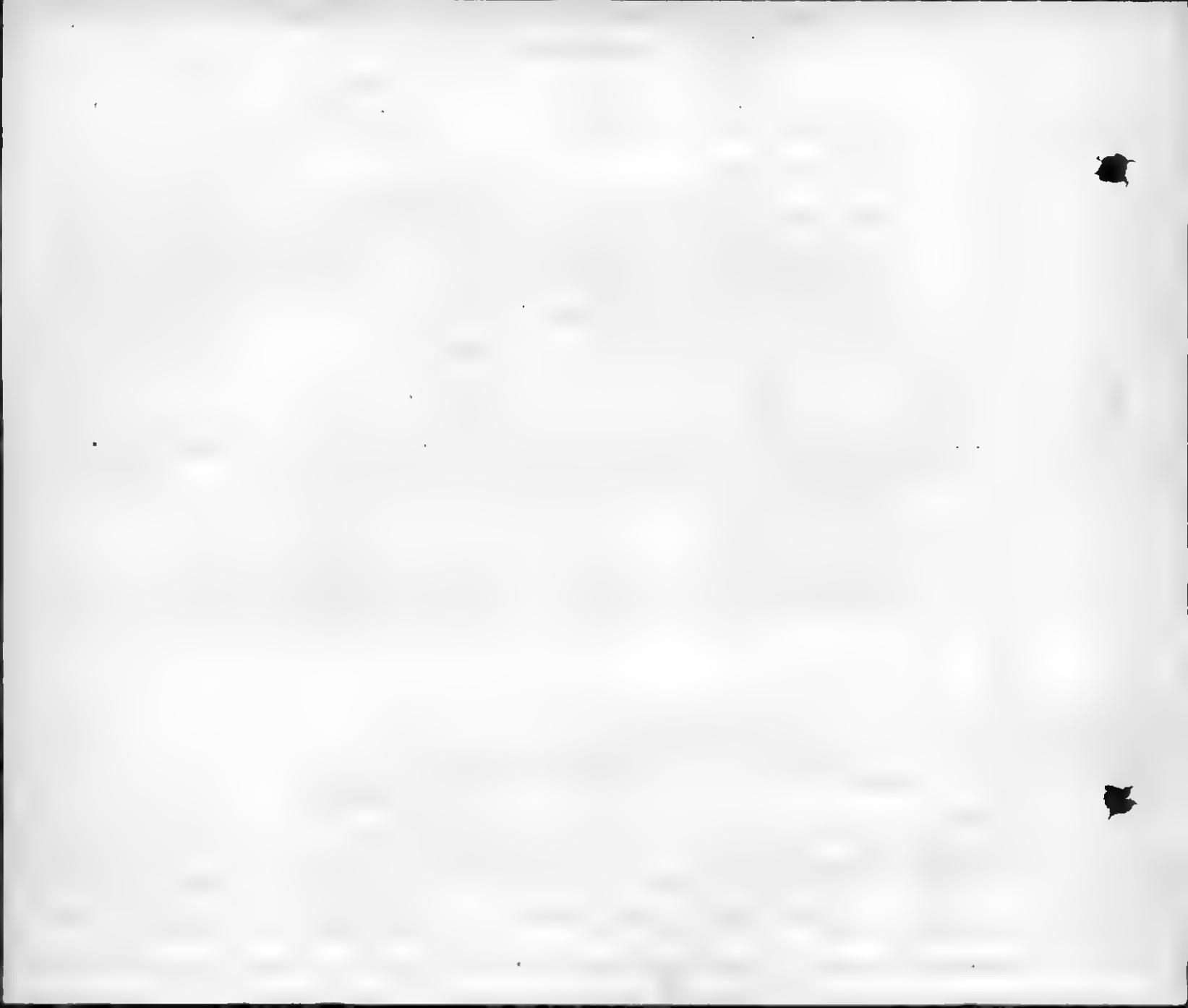
07239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
St. Mary's MARYLAND		a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avenue	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Rural	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Anthony	Last MORRIS
4. DATE OF DEATH	Month June	Day 5	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 March 1952
9. AGE (In years lost birthday) 6 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME Ruth A. Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Charles S. Morris	Address Avenue, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 months
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chaptico, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 17, 1958</u> to <u>June 5, 1958</u> , and that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Chaptico, Md. DATE SIGNED 6 June 1958		
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William D. Boyd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9 June 1958	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart	22d. LOCATION (City, town, or county) Bushwood
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson	ADDRESS Leonardtown, Md.	24a. REC'D BY REGISTRAR DATE JUN 12 1958	24b. REGISTRAR'S SIGNATURE John J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

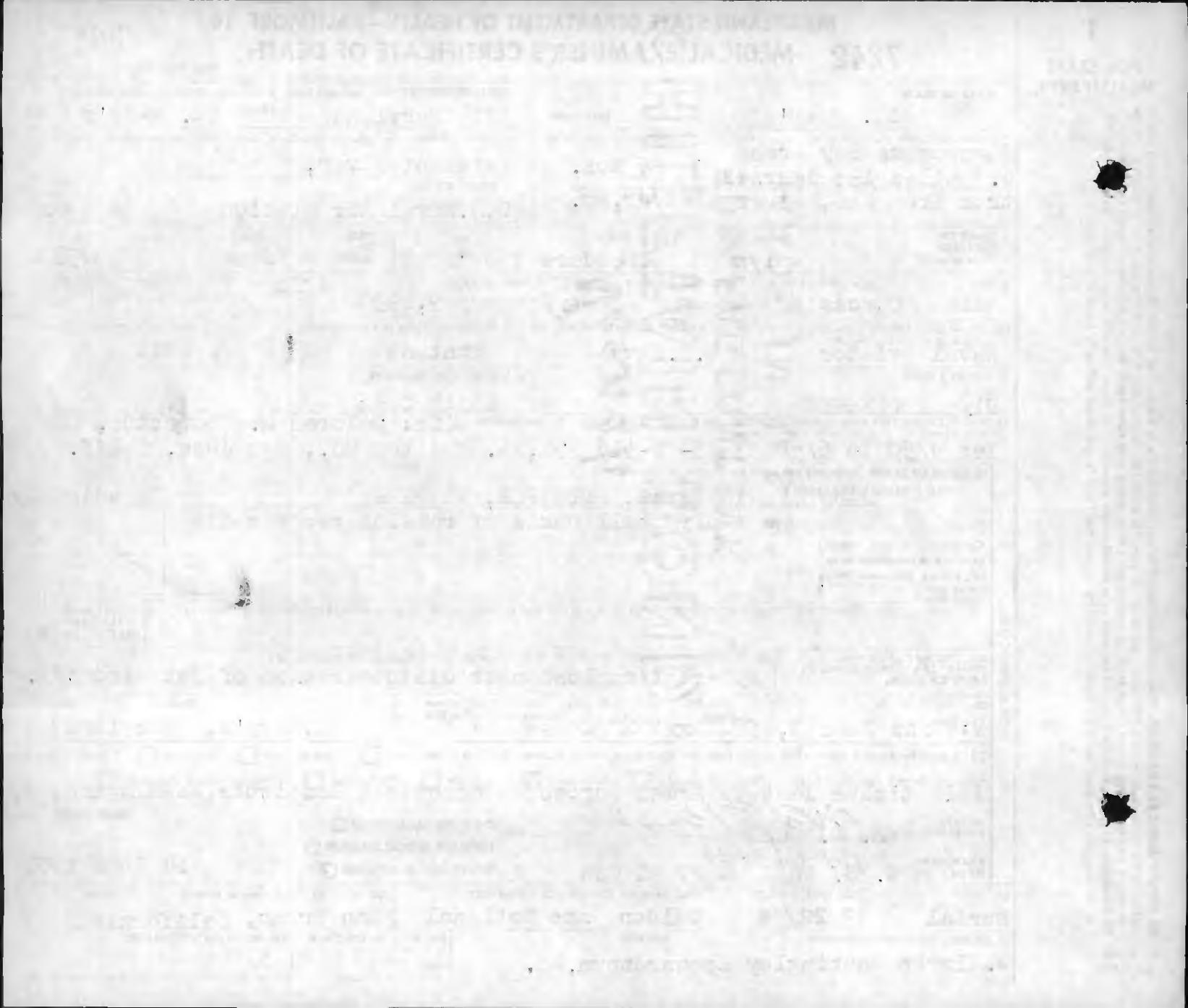
08368

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL Chesapeake Bay area		c. LENGTH OF STAY IN lb 15 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Patuxent River,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) true from NAS, Patuxent River, Md.				d. STREET ADDRESS U.S.Naval Air Station	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Glyn		First	Middle	Lost	4. DATE OF DEATH June 2 1958
5. SEX Male Caucasian		6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1930
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy		11. BIRTHPLACE (State or foreign country) Montana	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Glyn THORESTON		14. MOTHER'S MAIDEN NAME Edith CORA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 9/5d to 6/58		16. SOCIAL SECURITY NO. 3325-26-517		17. INFORMANT Wife: Dolores Adams Thoreston, Box 91, Mt. Hamilton Rd., San Jose, Calif.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <u>INJURIES, MULTIPLE, EXTREME</u> DUE TO (Only small parts of remains recovered) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 860X				INTERVAL BETWEEN ONSET AND DEATH Immediately	
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparent explosion or disintegration of jet aircraft.			
20c. TIME OF INJURY Month, Day, Year 9:40 AM June 2, 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay	
20f. (City or town) St. Mary's, Maryland				(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> (All tissue sent to Armed Forces Pathological Institute, Washington, DC)					
ACTUAL SIGNATURE WM. D. BOYD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 18 June 1958	
EXAMINER'S NAME (Type) W. S. WRAY, CAPT MC USN		22c. NAME OF CEMETERY OR CREMATORIUM Golden Gate National		22d. LOCATION (City, town, or county) San Bruno, California	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/58		24a. REC'D BY REGISTRAR DATE JUL 21 '58	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24b. REGISTRAR'S SIGNATURE Alt. Sedach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

7243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 10 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hermansville		d. STREET ADDRESS X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle F.	Last Unkle	4. DATE OF DEATH Jan. 1, 1878	Month June	Day 4	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 1, 1878	9. AGE (In years lost birthday) 80 yr.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Unkle				14. MOTHER'S MAIDEN NAME Caroline Osborne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-7757		17. INFORMANT Benjamin O. Unkle		Address St. Inigoes, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c). 420.1 Coronary sclerosis INTERVAL BETWEEN ONSET AND DEATH 1 week 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recurrent carcinoma (breast) with metastases to lungs & kidneys							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) August 1957, to Jan. 4, 1958					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Great Mills, Md.	(County)	(State)
21. I certify that I attended the deceased from August , 1957, to Jan. 4 , 1958, that I last saw the deceased alive on June 4, 1958 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 6/5/58							
ACTUAL SIGNATURE P. J. Bean, M.D.							
PHYSICIAN'S NAME (Type) P. J. Bean, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/7/58	22c. NAME OF CEMETERY OR CREMATORIAL Holy Face	22d. LOCATION (City, town, or county) Great Mills, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson				24a. REC'D BY REGISTRAR JUN 1 2 '58	24b. REGISTRAR'S SIGNATURE W. L. Edwards		
ADDRESS Leonardtown, Md.				DATE			

